

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The blank copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11825

11814

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH

COUNTY *Charles*
 CITY (If outside corporate limits, write RURAL
OR and give nearest town)
 TOWN *Port Tobacco*

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS
Rural

MARYLAND

LENGTH OF STAY
(In this place)

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE *Maryland* COUNTY *Charles*
 CITY (If outside corporate limits, write RURAL and give nearest town)
 TOWN *Port Tobacco*
 STREET ADDRESS
Rural

3. NAME OF
DECEASED
(Type or Print)

(First) *Baby* (Middle) *Say* (Last) *Adams*

4. DATE (Month) (Day) (Year)

SEX *Male* COLOR OR RACE *Negro* SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) *Single* DATE OF BIRTH *11-1-57* AGE last birthday *0* yrs. IF UNDER 1 YEAR
Months *0* Days *0* Hours *0* Min. *5*

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

*Maryland**USA*

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

*Elizabeth Adams*15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Mrs. Ruth Adams, Port Tobacco, Md.

18. MEDICAL CERTIFICATION

IMMEDIATE CAUSE

(A)

*Prematurity - 25 weeks*INTERVAL BETWEEN
ONSET AND DEATH*5 min.*

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(B)

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

M. at work

22. I hereby certify that I attended the deceased from *midday* to *19*, *19*, that I last saw the deceased alive on *19*, and that death occurred at *10:05* A.M. from the causes and on the date stated above.

SIGNATURE

J B Detter

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)*BURIAL*

DATE THEREOF

11/2/57

NAME OF CEMETERY OR CREMATORIAL

SACRED HEART

LOCATION (City, town, or county)

LA PLATA MD

(State)

24. REC'D BY REGISTRAR

Julia H. Pasay

REGISTRAR'S SIGNATURE

Julia H. Pasay

25. FUNERAL DIRECTOR'S SIGNATURE

Ruth Adams

ADDRESS

Port Tobacco, Md.

RECEIVED IN THE LIBRARY OF THE UNIVERSITY OF TORONTO

LIBRARY OF THE
UNIVERSITY OF TORONTO

BUREAU V. 2

NOV 5 1960

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11815 CERTIFICATE OF DEATH

11826
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 2 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains, Maryland	
3. NAME OF DECEASED (Type or print) Thomas J.		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept/29/1901
9. AGE (In years lost birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME William R. Beach		14. MOTHER'S MAIDEN NAME Mary C. Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 237 24 9725	
17. INFORMANT patient		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Hemorrhage Chronic lung abscess	
		19. INTERVAL BETWEEN ONSET AND DEATH 2 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 21, 1956 to Nov 1, 1957, that I last saw the deceased alive on Nov 1, 1957, and that death occurred at 900P.M., from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) La Plata, Md DATE SIGNED 11-1-57	
ACTUAL SIGNATURE F. M. JOHNSON M.D.		23. PHYSICIAN'S NAME (Type) F. M. JOHNSON M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-5-57	
22c. NAME OF CEMETERY OR CREMATORIAL Full Gospel		22d. LOCATION (City, town, or county) Cedarville	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		24a. ADDRESS Waco, Md.	
24b. REC'D BY REGISTRAR 11/5/57		24c. REGISTRAR'S SIGNATURE Julia H. Hanes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED	
BUREAU V. S.	
NOV 7 1957	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11827

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMJ. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Charles		Pomfret		Life				a. STATE Md b. COUNTY CHARLES	
								c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
								X2 Pomfret	
								d. STREET ADDRESS	
								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		MARRILYN		First Middle		4. DATE OF DEATH		Month Nov Day 18 Year 1957	
5. SEX F		6. COLOR OR RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH		9. AGE (in years last birthday)		10. UNDER 1 YEAR Months 0 yrs. Days 0 hrs. 11. UNDER 24 HRS. Hours 0 min.	
						APRIL 24-56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
				D.C.		USA.			
13. FATHER'S NAME Sweeney Beale		14. MOTHER'S MAIDEN NAME Mary P. Travers		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
								Address Pomfret	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		491X		DUE TO		Drowno- jacunie		INTERVAL BETWEEN ONSET AND DEATH 11-18-59	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO		(c)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
19									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE E. J. EDELEN		EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-18-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-57		22c. NAME OF CEMETERY OR CREMATORIAL St Joseph's Cem.		22d. LOCATION (City, town, or county) Pomfret		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Funeral Home		ADDRESS WALDORF, MD.		24a. REC'D BY REGISTRAR DATE 11/22/57		24b. REGISTRAR'S SIGNATURE Julia N. Passey			

WILDCAT EXPEDITION - MARCH - 1957
WILDCAT EXPEDITION CERTIFICATE OF DEATH

BUREAU V. S.

NOV 26 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11817

CERTIFICATE OF DEATH

11828
700

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hosp.		d. STREET ADDRESS 7102 14th Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First William	Middle Allen	Last Billingsley				
4. DATE OF DEATH	Month November	Day 11	Year 1957				
5. SEX Male	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1903				
9. AGE (In years from birthday) 54 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Federal Baking Company	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland					
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William B. Billingsley	14. MOTHER'S MAIDEN NAME Carrie B. Lusby						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 163X	16. SOCIAL SECURITY NO.	17. INFORMANT Roger H. Billingsley-5030 33rd Road, N.	Address Arlington, Va.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory collapse		INTERVAL BETWEEN ONSET AND DEATH 5 hrs.					
DUE TO 163X							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) C.U.A.		DUE TO 6 hrs.					
DUE TO 163X							
(c) Carcinoma, lung, with metastasis		DUE TO 9 mos.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15, 1957 to Nov 11, 1957 , that I last saw the deceased alive on Nov 11, 1957 , and that death occurred at 2:50A M , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE: Arthur O. Woody, M.D.							
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY, M.D. LA PLATA, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/13/57		22c. NAME OF CEMETERY OR CREMATORIUM McKendree Cemetery		22d. LOCATION (City, town, or county) Brandywine, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co.-2901 14th St., N.W.				ADDRESS Wash. D.C. 24a. REC'D BY REGISTRAR NOV 12 1957 24b. REGISTRAR'S SIGNATURE Julia Tosey			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Death Date

Place of Death

City of Death

State of Death

Country of Death

Place of Burial

City of Burial

State of Burial

Country of Burial

Place of Cremation

City of Cremation

State of Cremation

Country of Cremation

Place of Interment

City of Interment

State of Interment

Country of Interment

Place of Burial

City of Burial

State of Burial

Country of Burial

Place of Interment

City of Interment

State of Interment

Country of Interment

Place of Burial

City of Burial

State of Burial

Country of Burial

Place of Interment

City of Interment

State of Interment

Country of Interment

BUREAU OF

NOV 12 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11829

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		c. LENGTH OF STAY IN 1b 	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XI Waldorf	
3. NAME OF DECEASED (Type or print) Charles E. Burch		4. DATE OF DEATH Nov. 24 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug 20, 1907
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		9. AGE (in years last birthday) 50 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Ambrose Burch	
14. MOTHER'S MAIDEN NAME Mary E. Wood		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Edith Burch	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address WALDORE, Md.	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X		INTERVAL BETWEEN ONSET AND DEATH Instantly	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 		Fractured Skull & Fractured Neck	
(b) DUE TO		Crushed Chest, Bilateral Fractures (Comp)	
(c) DUE TO		Tibia & Fibula	
		Automobile Accident (Pedestrian)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian walking on highway hit by auto	
20c. TIME OF INJURY Month, Day, Year Hour 6 11-24-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Waldorf	
		(County) Charles Md.	
		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 11-25-57	
ACTUAL SIGNATURE Vernon B. Dettor		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Vernon B. Dettor, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-27-57	
22c. NAME OF CEMETERY OR CEMETORY St Peters Cem		22d. LOCATION (City, town, or county) WALDORE Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS WALDORE, Md.	
		24a. REC'D BY REGISTRAR Julia H. Hanes	
		DATE 11/30/57	
		24b. REGISTRAR'S SIGNATURE Julia H. Hanes	

RECEIVED - MEDICAL EXAMINER'S OFFICE - CITY OF DEATH

BUREAU Y.

DEC 3 1957

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this copy has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be retained by the hospital or attending physician.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11830

11819

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN)	CHARLES MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Maryland COUNTY Chas. Rural - ME Victoria
LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH Nov 1 1957	
(First) John		(Middle) Henry	
(Last) Carroll		(Day) (Year)	
5. SEX M	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9-16-81
9. AGE last birthday 76 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Henry Carroll		14. MOTHER'S MAIDEN NAME MARY CAROLINE CHAPMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. No	
17. INFORMANT & ADDRESS Hannah M. BUTLER		18. MEDICAL CERTIFICATION	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Respiratory collapse. C.V.A.	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 min	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1947, to Nov 1, 1957, that I last saw the deceased alive on Nov 1, 1957, and that death occurred at 5:45 P.M. from the causes and on the date stated above. SIGNATURE Sonwoody MD M.D. ADDRESS (Street, city, town, state) La Plata, Md. DATE SIGNED Nov 1, 1957			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-5-57	
NAME OF CEMETERY OR CREMATOR Y Shiloh ME Cem		LOCATION (City, town, or county) Wayside, Md.	
24. REC'D BY REGISTRAR DATE 11/6/57		REGISTRAR'S SIGNATURE Jessie H. Pasey	
25. FUNERAL DIRECTOR'S SIGNATURE Hink Funeral Home		ADDRESS	

RECEIVED

NOV 1 1967

RECEIVED

1 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 2 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or retrieval.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11831

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY		Charles Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE		Md Ches.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 4 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Jessie S		Middle		4. DATE OF DEATH	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-30	
9. AGE (Years 50 Months 0 Days 0 Yrs. 50)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Singer</i>		11. KIND OF BUSINESS OR INDUSTRY <i>None</i>		12. BIRTHPLACE (State or foreign country) <i>N.Y.</i>	
13. FATHER'S NAME <i>James Bryson</i>		14. MOTHER'S MAIDEN NAME <i>Christina Turner</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>640-34-0000</i>	
17. INFORMANT <i>Carol B. Reagan Jr.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Depressed failure</i> DUE TO <i>Fracture left humerus</i> Conditions, if any, which gave rise to immediate cause (b) <i>Fracture left humerus</i> DUE TO <i>Fracture left humerus</i> cause lost. (c) <i>Fracture left humerus</i>		19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour o. m. 10-18 p. m. 12-7		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Gwynedd</i> (County) <i>Montgomery</i> (State) <i>Md</i>					
22a. BURIAL, CREMATION REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>11-15-57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) <i>Bethesda Md</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archibald Inc</i>		ADDRESS <i>Laytonsville Md</i>		24a. REC'D BY REGISTRAR <i>Julia D. Basen</i>		24b. REGISTRAR'S SIGNATURE <i>Julia D. Basen</i>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 72 hours, prior to burial, removal, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11832
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pomonkey		c. LENGTH OF STAY IN lb 86-Yrs		d. STATE Maryland b. COUNTY Charles	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Pomonkey		f. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) William Thomas Day		First	Middle	Last	4. DATE OF DEATH 11-14-57
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-70	9. AGE (in years at birthday) 86 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY US*Govt.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Alice Campbell- (Daughter)-Bryans Road Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Small Intestines</u> 152 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) James E. Andrews		22d. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11-15-57	
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-18-57		22c. NAME OF CEMETERY OR CREMATORIAL Metropolitn Cem.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS W. Locust Md.		24a. REC'D BY REGISTRAR DATE 11/20/57	
				24b. REGISTRAR'S SIGNATURE Julia Hasen	

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LIBRARY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11822

CERTIFICATE OF DEATH

11833

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		b. COUNTY Charles		
c. LENGTH OF STAY IN 1b 13 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural - Cobb Island.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physician Memorial Hosp.		d. STREET ADDRESS 1		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Atticus	Middle M.	Last Earney	
4. DATE OF DEATH	Month Nov	Day 25	Year 1957	
5. SEX Male	6. COLOR OR RACE OS-W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 Mar 1887	
9. AGE (In years (last birthday) 70 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER	11. KIND OF BUSINESS OR INDUSTRY Industrial	12. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME M. D. EARNEY	14. MOTHER'S MAIDEN NAME Mary Chester	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) YES		
16. SOCIAL SECURITY NO. Per WWII	17. INFORMANT Regina M. Earney	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44ax DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first (b) C.U.A. DUE TO (c) Hypertension, renal disease INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Calculus prostate, chronically infected.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) —		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 1957, to <u>25 Nov.</u> , 1957, that I last saw the deceased alive on <u>25 Nov.</u> , 1957, and that death occurred at <u>4:46 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md. 27 Nov. 1957 DATE SIGNED				
ACTUAL SIGNATURE ARTHUR O. WOODY	M.D.			
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY MD				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-29-57	22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cem.	22d. LOCATION (City, town, or county) Arlington, VA. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS WALDOE, Md.	24a. REC'D BY REGISTRAR DATE 12/3/57	24b. REGISTRAR'S SIGNATURE Julia H. Pasey

BRUNSWICK V. S.

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11/20/68

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The death copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11834

11823

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Charles Pisgah	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		58 XO	7d Charles Pisgah (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH	
George N. Greer		Nov. 17 1957	
5. SEX Male	6. COLOR OR RACE Cpl.	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 9-13-89 9. AGE last birthday 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR Business	11. BIRTHPLACE (State or foreign country) Pisgah 7d
13. FATHER'S NAME George N. Greer		14. MOTHER'S MAIDEN NAME Rachel Ross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 312-14-8680	
17. INFORMANT & ADDRESS John R. Greer, Indian Head 2d		18. MEDICAL CERTIFICATION Coronary Occlusion 3 hrs.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C)		INTERVAL BETWEEN ONSET AND DEATH 54 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arthritis Generalized 54 hrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 11/7 1957 to 11/17 1957 that I last saw the deceased alive on 11/7 1957, and that death occurred at 4:20 A.M. from the causes and on the date stated above. SIGNATURE Frank A. Jason M.D. ADDRESS (Street, city, town, state) Indian Head, 7d DATE SIGNED 11-17-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 11-21-57	
24. REC'D BY REGISTRAR DATE 11/22/57		REGISTRAR'S SIGNATURE Julia H. Pasen	
25. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		ADDRESS Woodlawn, Md.	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13049

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. #5 HUGHESVILLE TRANSIENT		b. COUNTY ST MARY'S	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John		First	Middle
		Last DAVID HODGES Jr.	
4. DATE OF DEATH Month Day Year NOVEMBER 28 1957		Month Day Year	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Aug 28 1957
9. AGE (in years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) OKLA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME John D. Hodges		14. MOTHER'S MAIDEN NAME Dorothy Ellen Pate	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT John D. Hodges, Sr.		Address LEXINGTON PARK, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPHYXIACTION; ASPIRATION OF STOMACH CONTENTS 10 MINUTES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 216x (b) Brain Concussion 10 MINUTES DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. ON MD. RT #5, 1 MILE SOUTH OF HUGHESVILLE, MD.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) VEHICULAR COLLISION	
20c. TIME OF INJURY Month, Day, Year Hour 11/28 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIGHWAY	
20f. (City or town) HUGHESVILLE, CHARLES MD.		(County) OKLA.	
(State) OKLA.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John H. Griffin		DATE SIGNED 11/29/57	
EXAMINER'S NAME (Type) John H. Griffin, Acting		R.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 12-6-57	
22c. NAME OF CEMETERY OR CREMATORIAL HUNTER FUNERAL HOME		22d. LOCATION (City, town, or county) OKLA. CITY OKLA.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home		ADDRESS WALDOFF, MD.	
24a. REC'D BY REGISTRAR 12/9/57		24b. REGISTRAR'S SIGNATURE Julia Bobb-Perry	

REGATIVE

NEUTRAL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100
11835

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WASHINGTON b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT #6: HUGHESVILLE		c. LENGTH OF STAY IN 1b NOVIE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON, D.C.	
3. NAME OF DECEASED (Type or print) James		First THOMAS	Middle JORDAN
4. DATE OF DEATH NOVEMBER 28 1957		Month NOVEMBER	Day 28
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> July 27, 1913	9. AGE (In years last birthday) 44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY BLDG. MAINTENANCE	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME IRELAND JORDAN	
14. MOTHER'S M AIDEN NAME JANE M. FENWICK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT (WIFE) ESTELLE JORDAN Address 1369 PERRY PLACE, N.W.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRAC TURE, SKULL, BASIL 816X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MULTIPLE FRACTURES (3-4-5-6-7-8 RIBS, RT. TIBIA, RIGHT FEMUR; P. GHT GBLA) DUE TO ULNA; RIGHT TIBIA; RIGHT FEMUR; P. GHT GBLA INSTANTANEOUS (c) COMPOUND, COMMUNICATED FRACTURES OF LEFT TIBIA AND FIBULA INSTANTANEOUS		INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) TIBIA AND FIBULA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) ON MD. RT #6, 1 MILE SOUTH OF HUGHESVILLE, MD.	
20c. TIME OF INJURY Hour 11:20 p.m.		Month, Day, Year 11/28 1957	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HIGHWAY		20f. (City or town) HUGHESVILLE, CHARLES MD.	(County) CHARLES
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		22. ACTUAL SIGNATURE John H. Griffin	
ACTUAL SIGNATURE John H. Griffin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> , ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) John H. Griffin acting DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial Dec. 2 1957		22c. NAME OF CEMETERY OR CREMATORIUM St. Georges	22d. LOCATION (City, town, or county) St. Georges Island Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR Julia H. Roarty	24b. REGISTRAR'S SIGNATURE Julia H. Roarty
VS. A15ME(5) 5M 1/55		DATE 12/3/57	

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Item 20 Film 225 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11836
100

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the remains prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY CHARLES	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA	c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryantown RURAL									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Physicians Memorial Hosp.	e. STREET ADDRESS									
3. NAME OF DECEASED (Type or print) MICHAEL C.	4. DATE OF DEATH Last Month Day Year Proctor 11 3 1957									
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Feb 3 1944	9. AGE (in years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 11 3 0 0	11. IF UNDER 24 HRS. 0 0 0 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard Hayes Proctor Jr.	14. MOTHER'S MAIDEN NAME Catherine Proctor	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. —	17. INFORMANT HAYES Proctor WALDOFF, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fluid and Electrolyte Loss DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 916.0 Second Degree Thermal Burns - 100%. DUE TO (b) 15 hours (c) 15 hours					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Kerosene stove explosion					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Kerosene stove explosion				20c. TIME OF INJURY Month, Day, Year Hour 7:30 A.M. 11-2-1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Home	20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Home	20f. (City or town) Malcolm	(County) Charles	(State) Maryland
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE V. B. Dettor	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 5 Nov. 1957					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11-6-57	22c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART CEM	22d. LOCATION (City, town, or county) LA PLATA	(State) Md.						
23. FUNERAL DIRECTOR'S SIGNATURE Huntz Funeral Home	ADDRESS WALDOFF, Md.	24a. REC'D BY REGISTRAR 11/11/57	24b. REGISTRAR'S SIGNATURE Julia H. Passey							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11837

11827 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY		CHARLES		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE		Md		b. COUNTY		CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		LA PLATA		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		WELCOME		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Physicians Memorial Hosp.													
3. NAME OF DECEASED (Type or print)		First		Middle		4. DATE OF DEATH		Month		Day		Year			
DOROTHY		C.		SHORT		11		11		18		1957			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. FUNDER 1 YEAR		11. IF UNDER 24 HRS.			
FEMALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		March 17, 1928 29		yrs.		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
No Job				Md		USA									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
JESSIE Short		Emma Jordon													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
—		—		Emma Whiting 2205 Franklin NE		Wash., D.C.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		5X		Cerebral Hemorrhage				8 hrs.							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b)		Crusial Trauma				8 hrs.							
(c)		DUE TO		Auto Accident				8 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				Hyperthyroid Heart Disease											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		auto accident				19. WAS AUTOPSY PERFORMED?							
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
12:50 P.M.		11-18 1957		While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		Highway		Port Tobacco		CHARLES		MD			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE		J. B. Dettor						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED	
EXAMINER'S NAME (Type)		J. B. DETTOR, MD.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
22a. DOG AL. CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)									
Burial		11-20-57		Zion Hill Cem		Hill Top									
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
Hunt Funeral Home		Woods, Md.		DATE 11/22/57		Julia H. Passey									

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11838
100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VERONICA		First Sylvia	Middle Thompson
4. DATE OF DEATH 11-28		Month 11	Day 28
5. SEX F		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED 8-30-57
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENDANT		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) LA PLATA, MD
13. FATHER'S NAME Wm. GONZA Thompson		14. MOTHER'S MAIDEN NAME MARY Aline Proctor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT GONZA THOMPSON, LA PLATA, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 752X <i>Increased Intracranial Pressure</i>		INTERVAL BETWEEN ONSET AND DEATH 70 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Hydrocephalus</i>		70 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-10 , 1957, to 9-10 , 1957, that I last saw the deceased alive on 9-10 , 1957, and that death occurred at 2:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE V. B. Dettor 11-29-57			
PHYSICIAN'S NAME (Type) V. B. DETTOR, M.D.		22a. BURIAL, CREMATION, REMOVALS (Specify) BURIAL	
22b. DATE THEREOF 11/29/57		22c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPH'S	
22d. LOCATION (City, town, or county) BEL ALTON, MD		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE AREHART Funeral Home, LA PLATA		24a. REC'D BY REGISTRAR DATE 11/29/57	24b. REGISTRAR'S SIGNATURE Julia Basye
4000318X04			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EXHIBIT C TO DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11829

CERTIFICATE OF DEATH

11839

Reg. Dist. No.

101

1. PLACE OF DEATH a. COUNTY <i>Charles Co.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ironside- Md.</i>		b. COUNTY <i>Chas. Md.</i>	
c. LENGTH OF STAY IN 1b <i>1b</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ironside x3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		d. STREET ADDRESS <i></i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>SARAH</i>		First <i>H.</i>	Middle <i>WARRREN</i>
4. DATE OF DEATH <i>Nov 15 1957</i>		Month <i>Nov</i>	Day <i>15</i>
5. SEX <i>F</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>11-15-1886</i>		9. AGE (In years lost birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Chas. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Charles</i>	
13. FATHER'S NAME <i>John Henry Henson</i>		14. MOTHER'S MAIDEN NAME <i>Emma Queen Pisgah - Md.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Edna Simmmons, Ironside, Md.</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>0533</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Septicemia infected left foot	
		INTERVAL BETWEEN ONSET AND DEATH <i>Always</i>	
		3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>11-14 1957</i> to <i>11-15 1957</i> , that I last saw the deceased alive on <i>11-14 1957</i> , and that death occurred at <i></i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>F. M. JOHNSON MD.</i>		ADDRESS (Street, city or town, State) <i></i> DATE SIGNED <i>Re. Platoff, 11-18-57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-19-57</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Smith Chapel Church</i>		22d. LOCATION (City, town, or county) <i>Pisgah Chas. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Johnson and Jenkins</i>		24a. ADDRESS <i>4804 Georgia Ave.</i>	
		24b. REC'D BY REGISTRAR <i>7th</i> DATE <i>11-18-57</i>	
		24b. REGISTRAR'S SIGNATURE <i>Mary S. Smith</i>	

CERTIFICATE OF DEATH

BUREAU # 5

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